(C) The hearing is conducted by the CMS hearing officer who neither receives testimony nor accepts any new evidence that was not presented with the request for reconsideration. The CMS hearing officer is limited to the review of the record that was before CMS when CMS made either its initial RADV payment error calculation determination or its post-medical record review appeal payment error calculation determination and when the CMS reconsideration official issued the written reconsideration decision.

(D) The hearing officer has full power to make rules and establish procedures, consistent with the law, regulations, and CMS rulings. These powers include the authority to dismiss the appeal with prejudice or take any other action which the hearing officer considers appropriate for failure to comply with such rules and procedures.

(iv) *Decision of the CMS Hearing Officer*. The CMS hearing officer decides whether the reconsideration official's decision was correct, and sends a written decision to CMS and the MA organization, explaining the basis for the decision.

(v) *Effect of the Hearing Officer's decision*. The hearing officer's decision is final and binding, unless the decision is reversed or modified by the Administrator in accordance with paragraph (c)(5) of this section.

(vi) *Review by the CMS Administrator*. (A) CMS or a MA organization that has received a hearing officer's decision upholding or overturning a CMS initial or reconsideration-level RADV payment error calculation determination may request review by the CMS Administrator within 30 calendar days of receipt of the hearing officer's decision.

(B) At his or her discretion, the CMS Administrator can choose to either review or not review a case.

(C) If the CMS Administrator chooses to review the case, the CMS Administrator—

(*1*) Acknowledges his or her decision to review the hearing officer's decision in writing; and

(*2*) Determines whether to uphold, reverse, or modify the Hearing Officer's decision based on his or her review of the following:

(*i*) The Hearing Officer's decision.

(*ii*) Written documents submitted by CMS or the MA organization to the Hearing Officer.

(*iii*) Any other any other information included in the record of the Hearing Officer's decision.

(D) The Administrator notifies both parties of his or her determination regarding review of the hearing decision within 30 calendar days of receiving the request for review.

(E) If the Administrator chooses to review, the Administrator's determination is final and binding.

(F) The decision of the hearing officer is final if the Administrator—

(*1*) Declines to review the hearing decision; or

(*2*) Does not make a determination regarding review within 30 calendar days.

[75 FR 19806, Apr. 15, 2010; 75 FR 32859, June 10, 2010]

§ 422.312 Announcement of annual capitation rate, benchmarks, and methodology changes.

(a) *Capitation rates*—(1) *Initial announcement*. Not later than the first Monday in April each year, CMS announces to MA organizations and other interested parties the following information for each MA payment area for the following calendar year:

(i) The annual MA capitation rate.

(ii) The risk and other factors to be used in adjusting those rates under § 422.308 for payments for months in that year.

(2) CMS includes in the announcement an explanation of assumptions used and a description of the risk and other factors.

(3) *Regional benchmark announcement*. Before the beginning of each annual, coordinated election period under § 422.62(a)(2), CMS will announce to MA organizations and other interested parties the MA region-specific non-drug monthly benchmark amount for the year involved for each MA region and each MA regional plan for which a bid was submitted under § 422.256.

(b) *Advance notice of changes in methodology*. (1) No later than 45 days before making the announcement under paragraph (a)(1) of this section, CMS notifies MA organizations of changes it proposes to make in the factors and the

methodology it used in the previous determination of capitation rates.

(2) The MA organizations have 15 days to comment on the proposed changes.

§ 422.314 Special rules for beneficiaries enrolled in MA MSA plans.

(a) *Establishment and designation of medical savings account (MSA).* A beneficiary who elects coverage under an MA MSA plan—

(1) Must establish an MA MSA with a trustee that meets the requirements of paragraph (b) of this section; and

(2) If he or she has more than one MA MSA, designate the particular account to which payments under the MA MSA plan are to be made.

(b) *Requirements for MSA trustees.* An entity that acts as a trustee for an MA MSA must—

(1) Register with CMS;

(2) Certify that it is a licensed bank, insurance company, or other entity qualified, under sections 408(a)(2) or 408(h) of the Internal Revenue Code of 1986, to act as a trustee of individual retirement accounts;

(3) Agree to comply with the MA MSA provisions of section 138 of the Internal Revenue Code of 1986; and

(4) Provide any other information that CMS may require.

(c) *Deposit in the MA MSA.* (1) The payment is calculated as follows:

(i) The monthly MA MSA premium is compared with 1/12 of the annual capitation rate applied under this section for the.

(ii) If the monthly MA MSA premium is less than 1/12 of the annual capitation rate applied under this section for the area, the difference is the amount to be deposited in the MA MSA for each month for which the beneficiary is enrolled in the MSA plan.

(2) CMS deposits the full amount to which a beneficiary is entitled under paragraph (c)(1)(ii) of this section for the calendar year, beginning with the month in which MA MSA coverage begins.

(3) If the beneficiary's coverage under the MA MSA plan ends before the end of the calendar year, CMS recovers the amount that corresponds to the remaining months of that year.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 52027, Sept. 1, 2005]

§ 422.316 Special rules for payments to Federally qualified health centers.

If an enrollee in an MA plan receives a service from a Federally qualified health center (FQHC) that has a written agreement with the MA organization offering the plan concerning the provision of this service (including the agreement required under section 1857(e)(3) of the Act and as codified in § 422.527)—

(a) CMS will pay the amount determined under section 1833(a)(3)(B) of the Act directly to the FQHC at a minimum on a quarterly basis, less the amount the FQHC would receive for the MA enrollee from the MA organization (which includes the cost sharing amount the FQHC may charge an enrollee, as established in the contract between the FQHC and the MA organization); and

(b) CMS will not reduce the amount of the monthly payments under this section as a result of the application of paragraph (a) of this section.

[70 FR 4729, Jan. 28, 2005, as amended at 70 FR 76198, Dec. 23, 2005]

§ 422.318 Special rules for coverage that begins or ends during an inpatient hospital stay.

(a) *Applicability.* This section applies to inpatient services in a ''subsection (d) hospital'' as defined in section 1886(d)(1)(B) of the Act, a psychiatric hospital described in section 1886(d)(1)(B)(i) of the act, a rehabilitation hospital described in section 1886(d)(1)(B)(ii) of the Act, a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B) of the Act, or a long-term care hospital (described in section 1886(d)(1)(B)(iv)).

(b) *Coverage that begins during an inpatient stay.* If coverage under an MA plan offered by an MA organization begins while the beneficiary is an inpatient in one of the facilities described in paragraph (a) of this section—